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Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: focus on progress over the past 12 months

Report of the Secretary-General

Summary

At the High-Level Meeting on AIDS, held in New York on 2 June 2006, a new global objective was declared: moving towards the goal of universal access to HIV prevention programmes, treatment, care and support by 2010. The commitment to universal access establishes a major milestone on the road towards the achievement in 2015 of the Millennium Development Goals — especially the target under Goal 6, to have halted and begun to reverse the spread of HIVAIDS — but also of wider goals on poverty, education, gender equality, child mortality and maternal health. This commitment strengthens efforts to meet those made by Governments in the Declaration of Commitment on HIV/AIDS, entitled "Global Crisis — Global Action", adopted by the General Assembly at its twenty-sixth special session, in 2001.

As the halfway mark in the work to achieve the Millennium Development Goals approaches, the present report provides an overview of the most recent developments in the global AIDS response. It represents an interim assessment of the global AIDS response over the past 12 months, with a more comprehensive review planned in 2008, after countries submit progress reports as provided in the Political Declaration on HIV/AIDS.

Important groundwork has been laid over the past year for a longer-term effort to move towards universal access. Ninety lower- and middle-income countries set national targets by the end of 2006, and 25 countries have incorporated those targets into an updated, costed and prioritized national plan.

Recent data also suggest that progress has been made in other areas since the adoption of the Political Declaration, but that far greater action will be required to fulfil international commitments on AIDS. A major issue is to balance the need to

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scale up services and reach universal access in the shortest time possible and the need to strengthen existing infrastructures, including the capacity of civil society, to ensure the long-term sustainability of services.

Efforts to expand treatment continued to gather momentum. As of December 2006, an estimated 2.0 million people were receiving antiretroviral therapy in low- and middle-income countries, representing 28 per cent of the estimated 7.1 million people in need, an increase of 700,000 from the number estimated to be on antiretroviral therapy in December 2005. Nevertheless, the number of people dying from AIDS increased from 2.2 million in 2001 to 2.9 million in 2006. The increase in deaths is largely the result of an increase in the number of people with advanced HIV infection in need of antiretroviral therapy, whose numbers are rising faster than the scale-up of retroviral therapy.

The universal access process also needs to intensify efforts to prevent new HIV infections. The past failure of prevention measures to keep pace with the epidemic's growth are largely attributable to three problems: (a) insufficient investment in prevention; (b) low coverage of HIV prevention services for populations with higher rates and risks of HIV infection; and (c) lack of action against the social, economic and cultural drivers of HIV infection, including gender inequality, stigma and discrimination and the failure to protect other human rights.

National target-setting processes have highlighted fundamental challenges to scaling up significantly. For example, few countries have demonstrated clearly how they will overcome key obstacles to universal access, such as weak health systems, insufficient human resources, lack of predictable and sustainable financing and lack of access to affordable services.

In low- and middle-income countries, current estimates of global resource needs for HIV are $18 billion in 2007 and $22 billion in 2008. An estimated $10 billion — an increase over the $8.9 billion available in 2006 — will be available for HIV-related programmes in those countries in 2007, slightly more than half of what is needed. As many countries, especially low-income countries, cannot achieve the universal access goals without external resources, there is a pressing need for more international funding for public health and development.

With the passage of the epidemic's first 25 years, it has become clearer than ever that the global response must move from an emergency footing to a longer-term effort that lays the groundwork for sustainable progress. HIV funding provides an opportunity and entry point for strengthening health and social service systems. When strategically used, resources for AIDS can improve health infrastructure, leading to increased immunizations for children, safer hospital environments and better access to basic services for other health problems. To enhance long-term sustainability, HIV programmes should be closely integrated with other relevant services.

Ultimately, many countries continue to struggle to significantly increase the pace of scaling up and move towards the goal of universal access by 2010. Strengthening the global response and fully implementing prior commitments made by Member States requires that countries "know their epidemic" and intensify HIV prevention; chart their course towards universal access to HIV prevention and treatment; fund ambitious, credible national HIV plans and align them with their existing national systems; be able to review and report on progress regularly; and build capacities for a stronger, more sustainable response.

"We, Heads of State and Government and representatives of States and Governments ... commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010"[1]

— Political Declaration on HIV/AIDS

I. Introduction

1. One year ago, the international community significantly strengthened its commitment to reverse the spread of HIV and the annual death toll caused by AIDS. At the High-Level Meeting on AIDS, held in New York on 2 June 2006, a new global objective was declared: universal access. By its resolution 60/262 of 2 June 2006, the General Assembly adopted the Political Declaration on HIV/AIDS, which sets out the requirements for moving countries towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.

2. The commitment to universal access establishes a major milestone on the road towards the achievement of the Millennium Development Goals, especially the target, under Goal 6, to have halted by 2015 and begun to reverse the spread of HIV/AIDS — but also of goals on poverty, education, gender equality, child mortality and maternal health. Over the past 12 months, the overall concept of universal access has evolved, and the essential elements of the process have become better defined. The commitment to universal access is not a target itself. Instead, it emphasizes the need for far greater urgency, equity, affordability and sustainability in national responses to AIDS, as well as a comprehensive and multisectoral approach to AIDS. Universal access involves mobilizing relevant stakeholders in countries so that they define their own goals. In the Political Declaration, Governments therefore made a commitment to rapidly set national targets that reflect the urgent need to scale up towards the goal of universal access by 2010.

3. The Political Declaration reinforces efforts to meet the commitments made by Governments in the Declaration of Commitment on HIV/AIDS, entitled "Global Crisis — Global Action".[2] National reporting of progress towards the commitments in both declarations will continue along the current two-year cycle, with the next round of country progress reports due by 31 January 2008. The Joint United Nations Programme on HIV/AIDS (UNAIDS) will then analyse the data, and a comprehensive progress report will be submitted to the General Assembly in 2008, as agreed to in the Political Declaration.

4. The present report focuses on the interim progress achieved since the High-Level Meeting on AIDS, including the status of national target setting, new data on coverage for key interventions and an assessment of the political commitment to the response, including the estimates of funding available for 2007. In addition, UNAIDS will release an annual report in June 2007 that will highlight the roles and

[1] See General Assembly resolution 60/262, annex.

[2] General Assembly resolution S-26/2 of 27 June 2001, annex.

specific contributions made by the United Nations and will complement the contents of this report.[3]

5. With the passage of the epidemic's first 25 years, it has become clearer than ever that the global response must move from an emergency footing to a longer-term effort that lays the groundwork for sustainable progress. Therefore, it will be necessary to establish sound, reliable financing schemes and implement strategies to build and preserve national infrastructure, including an investment in civil society. There will also be a need to accelerate those interventions that address the drivers of the epidemic such as gender inequality, stigma and discrimination and the failure to protect human rights.

II. Developments since the adoption of the Political Declaration on HIV/AIDS: moving towards universal access

6. Selected progress has been achieved in moving towards universal access over the past 12 months, and section II describes the major elements in the process thus far. Those elements include changes in the political environment, setting national targets, estimating resource needs, expanding treatment and intensifying prevention. A number of challenges remain. Many national plans still do not adequately address the costs of non-health sector prevention interventions and second-line antiretroviral therapy or the costs of supporting orphans and investments in infrastructure. Non-health sector interventions include programmes that prioritize the following: youth, both in and out of school; community mobilization; men who have sex with men; harm reduction for injecting drug users, and worksite interventions. In moving towards a longer-term response, it is also clear not only that more financial resources are needed for AIDS, but also that resources should be used in more strategic and innovative ways to deliver more effective prevention and treatment programmes, through stronger public social services and expanded community efforts.

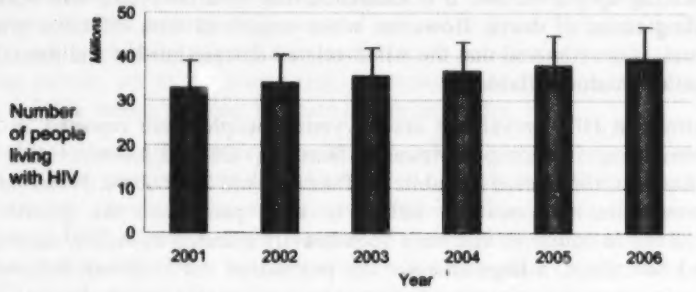
A. Status of the global AIDS epidemic

7. By the end of 2006, an estimated 39.5 million people worldwide were living with HIV infection. That figure represents a considerable increase since 2001, when an estimated 32.9 million people were living with HIV (figure 1). The rate of people newly infected with HIV has remained around 4 million per year, while the number of people dying from AIDS has grown from 2.2 million in 2001 to 2.9 million in 2006 (figure 2). The increase in deaths is largely the result of an increase in the number of people with advanced HIV infection and in urgent need of treatment,[4] whose numbers are rising faster than the scale-up of antiretroviral therapy.

[3] See http://www.unaids.org/en/AboutUNAIDS/Governance/20070625-pcb20.asp.

[4] As defined by the World Health Organization treatment guidelines.

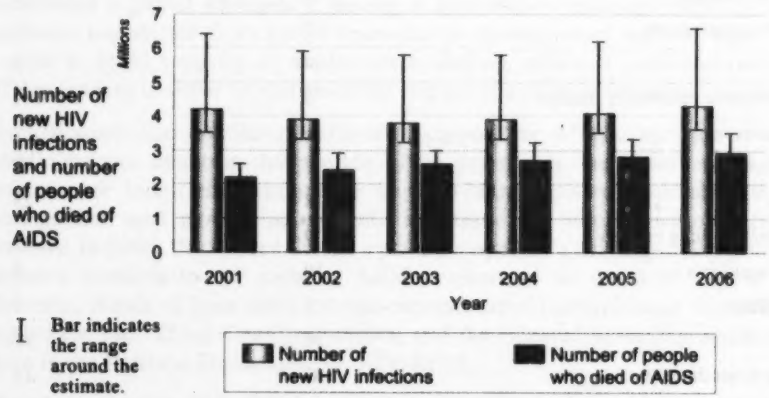
Figure 1
Estimated number of people living with HIV globally, 2001-2006



I Bar indicates the range around the estimate.

Note: See Joint United Nations Programme on HIV/AIDS and World Health Organization, *AIDS Epidemic Update* (UNAIDS/06.29E) (Geneva, December 2006). Available from http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf.

Figure 2
Estimated number of new infections and number of people who died of AIDS, 2001-2006



Note: See Joint United Nations Programme on HIV/AIDS and World Health Organization, *AIDS Epidemic Update* (UNAIDS/06.29E) (Geneva, December 2006). Available from http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf.

8. Globally in 2002, AIDS was the fourth leading cause of death. If the scaling up of AIDS treatment programmes consists solely of scaling up antiretroviral therapy without scaling up prevention, it is estimated that by 2030 AIDS will become the third leading cause of death. However, when combined with effective prevention programmes, it is estimated that the AIDS-related disease burden and mortality will be substantially reduced (table 1).

9. Declines in HIV prevalence among young people were reported in 2006 in several countries, including Botswana, Burundi, Côte d'Ivoire, Haiti, Kenya, Malawi, Rwanda, the United Republic of Tanzania and Zimbabwe. However, on the whole, prevention measures are failing to keep pace with the growth of the epidemic. Even in countries that have been heavily affected by AIDS, such as South Africa and Swaziland, a large share of the population still does not believe it is at risk. In most countries, stigma and discrimination against people living with HIV further discourage many from taking an HIV test and disclosing their status to sexual partners.

Table 1
Changes in rankings for 15 leading causes of death, 2002 and 2030

Disease or injury	*2002 rank*	*2030 rank*
Ischaemic heart disease	1	1
Cerebrovascular disease	2	2
Lower respiratory infections	3	5
HIV/AIDS	4	3
Chronic obstructive pulmonary disease	5	4
Perinatal conditions	6	9
Diarrhoeal diseases	7	16
Tuberculosis	8	23
Trachea, bronchus, lung cancers	9	6
Road traffic accidents	10	8
Diabetes mellitus	11	7
Malaria	12	22
Hypertensive heart disease	13	11
Self-inflicted injuries	14	12
Stomach cancer	15	10
Nephritis and nephrosis	17	13
Colon and rectum cancers	18	15
Liver cancers	19	14

Source: Colin D. Mathers and Dejan Loncar, "Projections of global mortality and burden of disease from 2002 to 2030", *PLoS Medicine*, vol. 3, No. 11 (November), table 2.

10. Gender inequality continues to drive a feminization of the epidemic, though the dynamics of this feminization are changing. Increasing numbers of married women, in addition to girls and young women, are becoming infected. In many regions, more girls and women of 15 years of age and older are living with HIV than ever before, while globally women now comprise 48 per cent of people living with HIV. Young people are at particular risk, accounting for 40 per cent of the new infections in 2006 among persons 15 years of age and older.

11. Globally, injecting drug users, sex workers, prisoners, migrants and men who have sex with men are regularly denied access to information and services and are often subjected to discrimination and violence, leaving them among the populations most at risk of HIV infection. Over the past two years HIV outbreaks among men who have sex with men have become evident in Cambodia, China, India, Nepal, Pakistan, Thailand and Viet Nam. Recently, injecting drug use has emerged as a new factor for HIV infection in sub-Saharan Africa, especially in Mauritius, but also in Kenya, Nigeria, South Africa and the United Republic of Tanzania. Unfortunately, such trends have not always triggered a commensurate national prevention response.

B. The political environment and the move towards universal access

12. Political commitment with respect to AIDS continued to grow in 2006, as reflected most notably in the Political Declaration on HIV/AIDS adopted during the High-Level Meeting on AIDS. The General Assembly recognized that the epidemic constituted a global emergency, posing a formidable challenge. Now the political emphasis has shifted from global consensus to country-level actions, where there is a need to build capacity to implement scaled-up, efficient, multisectoral national HIV responses in order to maximize the impact of available financial resources.

13. Bilateral and multilateral efforts to support the AIDS responses of low- and middle-income countries have often given priority to the achievement of rapid results over long-term, sustainable impact. Many donors established their own management and monitoring systems in parallel to broader national plans and systems. In 2004, the "Three Ones" were developed as a set of guiding principles to improve coordination of national AIDS responses.[5] In the 2005 World Summit Outcome, Heads of State and Government committed themselves to work actively to implement the "Three Ones" principles, and the General Assembly again endorsed them in the Political Declaration on HIV/AIDS.

14. According to UNAIDS data, by January 2007, a total of 73 low- and middle-income countries had established a national AIDS framework that was developed through an inclusive, multipartner process; 51 of those frameworks have served as the basis for negotiations for the funding contributions of all major partners. However, key planning components are missing in many countries. Only 49 countries have a process in place for regular participatory reviews of progress, and only 40 countries with national frameworks have translated them into costed operational plans. Regarding the "Third One", the national monitoring and evaluation system, UNAIDS data suggest that 56 low- and middle-income countries

[5] The "Three Ones" call on international and national partners to align their efforts around one agreed AIDS action framework, coordinated by one national AIDS coordination authority with a broad-based multisectoral mandate and monitored through one agreed national monitoring and evaluation system.

have functional monitoring and evaluation systems but only 35 have mechanisms in place to collect and analyse reports from major partners.

15. In 2006, to support the implementation of the "Three Ones" in countries, the UNAIDS Secretariat and the World Bank developed the country harmonization and alignment tool (CHAT). The country harmonization and alignment tool serves as a framework and tool for countries to assess how well international and national organizations are integrating their programmes within countries.[6] Initial findings from the use of this new tool suggest that international partners are not fully respecting the commitments of the Rome Declaration on Harmonization of 2003 and the Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability of 2005. Results from seven countries described the level of engagement of civil society and showed that involvement in planning by no means guaranteed involvement in other critical process areas, such as discussions on resource allocation.

16. While it is clear that additional progress is needed to ensure full implementation of the "Three Ones" at the country level, several "good practices" have emerged in recent years regarding the alignment of international efforts to national priorities. In Mozambique, for example, a code of conduct was signed in 2006 by the national Government, donors, civil society and the United Nations system. The Mozambique code defines the principles, mechanisms and functioning of a national partners forum, including monthly coordination meetings, annual joint reviews and evaluation processes, and technical assistance to the national AIDS coordinating authority.

C. National target setting for moving towards universal access

17. The Political Declaration on HIV/AIDS called on all countries to set, by the end of 2006, ambitious national targets on HIV prevention, treatment, care and support that reflected their commitment to move towards the goal of universal access by 2010. Clear national targets — including interim or process targets for 2008 and outcome targets for 2010 — promote partner alignment to national priorities and hold countries directly accountable for reaching the targets they have set themselves. Established targets also facilitate efforts by countries and international partners to mobilize international support and resources.

18. The target-setting process recommended by UNAIDS[7] brings together a wide range of stakeholders, including civil society representatives, offers a critical framework for assessing national commitments, supports efforts by Governments to tailor their responses to the particular nature and needs of their epidemics and encourages transparency and accountability.

19. By the end of 2006, 90 low- and middle-income countries had set targets. For example, in West and Central Africa, several countries have set ambitious targets to increase coverage of services for antiretroviral treatment and the prevention of

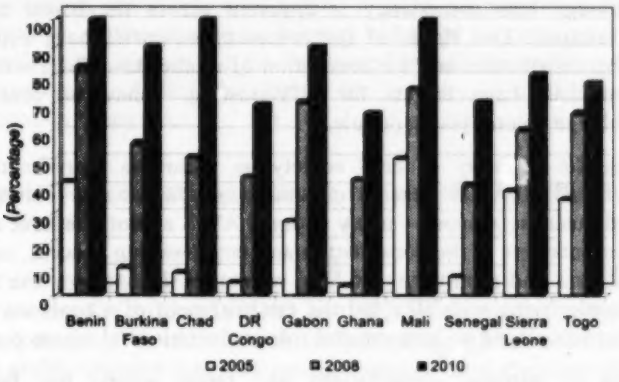
[6] The country harmonization and alignment tool was piloted in the following seven countries in late 2006: Botswana, Brazil, the Democratic Republic of the Congo, Indonesia, Nigeria, Somalia and Zambia.

[7] UNAIDS, "Setting national targets for moving towards universal access: operational guidance" (Geneva, 2006).

mother-to-child transmission of HIV, and they are updating their national strategic programme accordingly (figures 3 and 4).

Figure 3

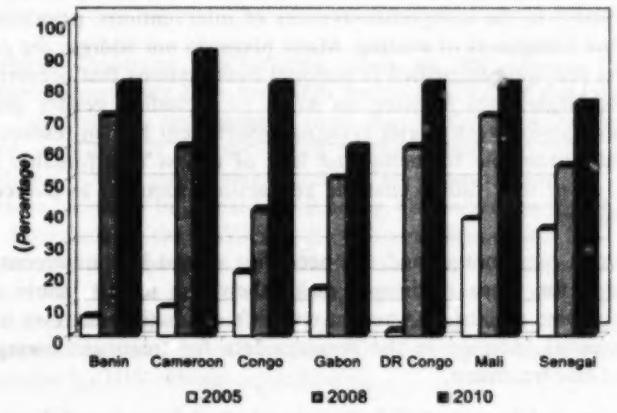
Women, men and children with advanced HIV infection who were receiving antiretroviral treatment in 2005, and projected targets for 2008 and 2010 in a number of sub-Saharan African countries



Source: UNAIDS, based on data presented at a UNAIDS senior management retreat, Glion, Switzerland February 2007.

Figure 4

HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission in 2005, and projected targets for 2008 and 2010 in a number of sub-Saharan African countries



Source: UNAIDS, based on data presented at a UNAIDS senior management retreat, Glion, Switzerland February 2007.

20. At the end of 2006, Kenya launched a rapid results initiative, requesting districts to set targets on treatment to be achieved in 100 days. The results were extraordinary: almost all districts exceeded their set targets, demonstrating the motivating power and prioritization of action that can result from target setting.

21. Of the 90 countries that had set targets by the end of 2006, 81 countries had established treatment-related targets, 51 countries had set targets on care for orphans and vulnerable children, and 84 countries had established at least one prevention-related target, though less consistency is apparent across the broad range of prevention interventions. Two thirds of the preceding countries have established targets for condom distribution and for prevention of mother-to-child transmission, while only about half have targets for HIV testing, behaviour change and appropriate knowledge among young people.

22. Recognizing the diversity of civil society — including representatives of people living with HIV, AIDS service organizations, faith-based communities, labour unions and business groups — many national AIDS authorities have engaged civil society representatives in the consultation and target-setting process, including in the implementation and monitoring of HIV responses. In Malawi, the national association of people living with HIV led the establishment of a coalition of civil society groups that has played an instrumental role in the universal access process.

23. The process of national consultations and target setting has facilitated consensus-building among partners about ways of scaling up towards universal access, and it has created a renewed interest in intensifying prevention interventions in order to sustain treatment efforts. However, reports from some countries also indicate concerns that, if the targets are overly ambitious, the impact of setting such targets can be undermined.

24. Following the setting of targets, about 70 countries are in the process of developing or updating their national AIDS plan to incorporate the targets, and a total of 25 countries have already costed their updated plan. A review by UNAIDS of these plans for scaling up reveals, however, that their quality is uneven, in particular with respect to the comprehensiveness of interventions, prioritization of planned actions and robustness of costing. Many plans do not address the obstacles to universal access that were identified in national consultations that occurred in the months before the High-Level Meeting on AIDS — including gender inequality, stigma and discrimination, weak health systems, insufficient human resources, lack of predictable and sustainable financing and lack of access to affordable services and commodities — or they fail to cost the key actions required to overcome the obstacles to scaling up.

25. Many countries have not costed the need for second-line treatment, as the current high prices for those medicines make their use unsustainable in most low- and middle-income countries. A recent resource estimation exercise in Kenya showed an exponential increase in the requirements for treatment owing to the addition of second-line treatment.

26. Some countries that have costed their national plans have found the processes to be an uncomfortable "reality check" regarding the availability of funding and the sustainability of ambitious plans. For example, Zambia's plan for scaling up, which included actions to address the crisis in human resources, set a target of 50 per cent coverage because the Government was uncertain whether its domestic contribution

could sustain scaling up at a higher coverage level. Mauritania used a costing exercise within the context of its mid-term expenditure framework as an opportunity for additional internal and external resource mobilization.

27. Some countries face difficulties with resource mobilization from international or national sources owing to poor performance track records, making it even more difficult to set and achieve ambitious targets. Improved utilization of available resources should be a shared concern of Governments and development partners alike, requiring enhanced coordination of technical support and the harmonization of efforts. A major issue is to balance the need to scale up services and reach universal access in the shortest time possible and the need to strengthen existing infrastructures, including developing the capacity of civil society, to ensure the sustainability of services.

D. Financial resources: how much is needed and where will it come from?

28. Current estimates of global resource needs for HIV in low- and middle-income countries are $18 billion in 2007 and $22 billion in 2008. The needs of lower-income countries[8] account for about half of the global resource needs for 2008. Lower middle-income countries are estimated to need about one third of total global resource needs, or around $6.5 billion in 2008.

29. An estimated $10 billion will be available for HIV-related programmes in low- and middle-income countries in 2007. While this will represent an increase over the $8.9 billion that was available in 2006, it represents only slightly more than half of the $18 billion that is estimated to be needed in 2007.

30. As many countries cannot achieve the universal access goals without external assistance, there is a pressing need for more international funding for public health and development. Countries that are able to do so, especially those with strong and growing economies, must also invest more of their own money on HIV and health in general.

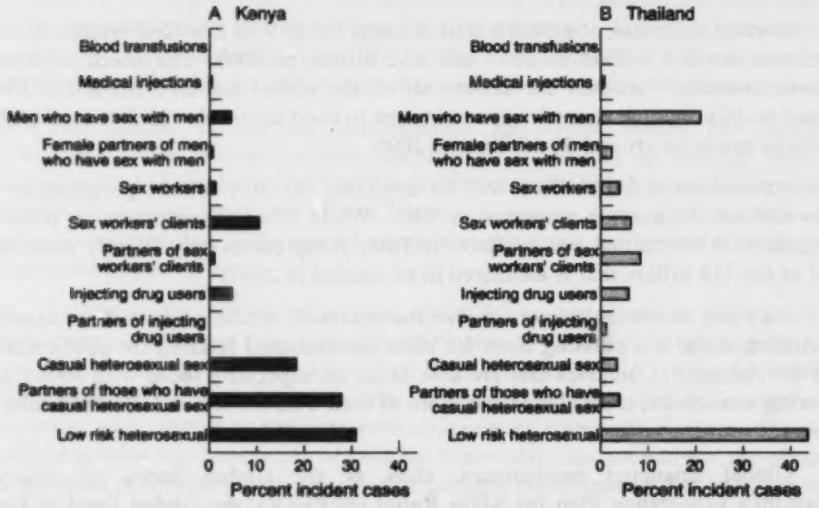
31. Global financing mechanisms, such as the United States of America President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank, as well as innovative resource mobilization schemes such as the airline levy used by UNITAID, the international drug purchasing facility, are contributing to more stable and predictable increases in global HIV funding. Organizations like the Bill and Melinda Gates Foundation, the William J. Clinton Foundation and others are also contributing significantly to HIV funding and technical support. Public and private insurance schemes for financial and social protection are also important to guarantee the predictability and sustainability of funding and to mitigate the risk of impoverished households, affected by HIV, having to use a significant portion of their income for HIV-related expenditures.

[8] Countries with a gross national income per capita of less than $875.

E. Addressing the drivers of the epidemic

32. There is not only a need to spend more, but also to spend more wisely to obtain optimal lasting results. Decisions about which activities are funded or which ones are funded first must be based on an evidence-informed analysis of the epidemiology of HIV infection and the behaviours and social conditions that impede people's access to and use of HIV information and services. Information on how people become infected can provide policymakers with important information on the nature of the epidemic in their country. "Knowing your epidemic" is therefore a critical basis for prioritizing the national AIDS response, as seen in the data (figure 5), which illustrate that there are most-at-risk populations who may need specialized services in both a generalized epidemic and a concentrated one.

Figure 5
Distribution of per cent incident cases by mode of exposure


A Kenya
Blood transfusions
Medical injections
Men who have sex with men
Female partners of men who have sex with men
Sex workers
Sex workers' clients
Partners of sex workers' clients
Injecting drug users
Partners of injecting drug users
Casual heterosexual sex
Partners of those who have casual heterosexual sex
Low risk heterosexual
0 10 20 30 40
Percent incident cases
B Thailand
Blood transfusions
Medical injections
Men who have sex with men
Female partners of men who have sex with men
Sex workers
Sex workers' clients
Partners of sex workers' clients
Injecting drug users
Partners of injecting drug users
Casual heterosexual sex
Partners of those who have casual heterosexual sex
Low risk heterosexual
0 10 20 30 40
Percent incident cases

Source: E. Gouws, and others, "Short-term estimates of adult HIV incidence by mode of transmission: Kenya and Thailand as examples", *Sexually Transmitted Infections*, vol. 82, *Supplement No. 3*.

33. However, in many countries there is limited willingness or capacity to focus on the legal, social, economic and cultural issues that drive the epidemic. Groups known to be most at risk of infection — such as sex workers, injecting drug users and men who have sex with men — rarely receive targeted services, resulting in ineffective responses. Overt and covert stigmatization and discrimination against these groups is a significant factor impeding data collection and targeted funding and programming.

34. Similarly, in countries with high HIV prevalence, women, young women and men, prisoners and migrants are particularly vulnerable to HIV infection, and yet these groups often receive few HIV programming interventions dedicated to their specific needs. Insufficient funding or programming is directed at addressing gender

inequality, stigma and discrimination and violence against women and girls, all of which increase their vulnerability to HIV infection and to the impact of AIDS.

35. In the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, Governments fully recognized the importance of human rights and gender equality in national responses to HIV and committed themselves to action in those areas, but programmatic responses promoting human rights and gender equality in the response to HIV have yet to be prioritized. Those responses include the following: law reform; training of law enforcement personnel to promote and protect access of vulnerable groups to HIV prevention, treatment, care and support; training of health-care workers in informed consent, non-discrimination and confidentiality in respect of HIV; efforts to end harmful traditional norms such as child marriage, violence against women and female genital mutilation; efforts to make schools free of sexual violence for girls; and provision of HIV services to prisoners.

Know your epidemic and your current response

Programming for effective HIV prevention requires action to take on the drivers of the epidemic at the community level. Policymakers and programmers have to know their epidemic: who is getting infected and what are the linkages between risk behaviours, vulnerabilities and the economic, legal, political, cultural and psychosocial conditions. Such assessments should engage communities and members of vulnerable populations in identifying what factors are determining vulnerability, what stands in the way of obtaining and using HIV information and services and what is necessary to overcome the barriers.

Drivers and risk factors

The term "drivers of the epidemic" relates to the structural and social factors, such as poverty, gender inequality and human rights violations, that increase people's vulnerability to HIV infection but are not easily measured. The term "risk factors" is defined by *A Dictionary of Epidemiology*, third edition, as "an aspect of personal behaviour or lifestyle, an environmental exposure or an inborn or inherited characteristic, which on the basis of epidemiologic evidence is known to be associated with health-related condition(s) considered important to prevent". These include behaviours such as injecting drug use, unprotected casual sex and multiple concurrent partners over a longer period of time with low and inconsistent condom use.[a]

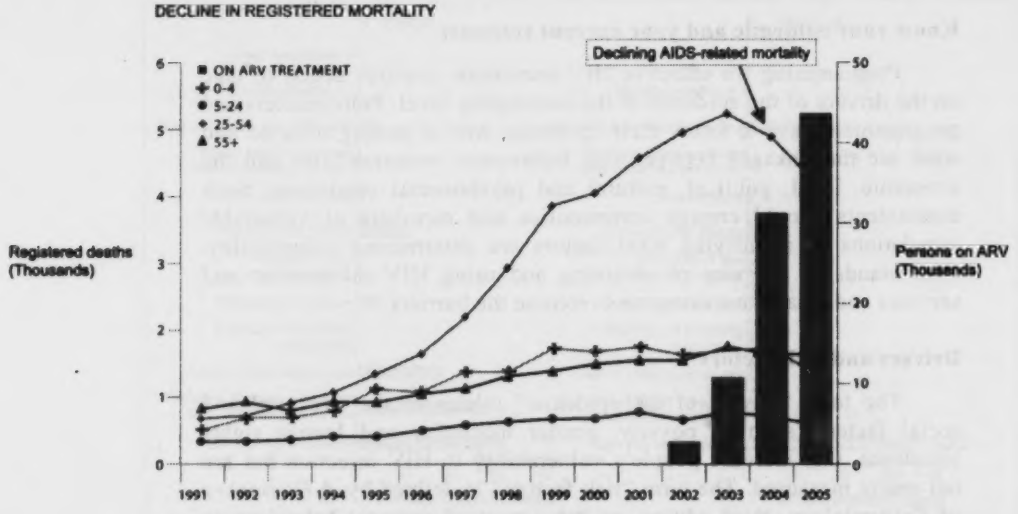
Source: John M. Last, editor, *A Dictionary of Epidemiology*, 3rd edition (New York, Oxford University Press, 1995).

[a] Recently the term "driver" has also been used to describe those risk factors that are so widespread as to account for the increase and maintenance of an HIV epidemic at the population level.

F. Expansion of treatment services

36. Access to life-saving treatment services is a pivotal component of universal access. As of December 2006, an estimated 2.0 million people were receiving antiretroviral (ARV) therapy in middle- and low-income countries, representing 28 per cent of the estimated 7.1 million people in need, an increase of 700,000 from the estimated treatment coverage in December 2005. In sub-Saharan Africa, 1.3 million people were receiving antiretroviral treatment, or 28 per cent of those in need, compared with just 100,000 on treatment and 2 per cent coverage three years earlier. The impact on mortality of the scaling up of antiretroviral therapy has been demonstrated in a number of countries, as illustrated by the example in figure 6.

Figure 6
Botswana: decline in registered adult mortality in age groups with implementation of antiretroviral therapy



Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria, Partners in Impact: Results Report (Geneva, 2007), figure 39.

37. According to the World Health Organization (WHO) data, estimated treatment coverage is 19 per cent in Asia, 72 per cent in Latin America and the Caribbean and 14 per cent in the low- and middle-income countries of Europe and Central Asia. The lowest regional coverage is in the Middle East and North Africa, where only 5 per cent of those needing treatment are currently receiving it.

38. Coverage for children requiring treatment with antiretroviral drugs is especially low. In low- and middle-income countries, no more than 8 per cent of HIV-positive children estimated to be in need of antiretroviral drugs have access to them. Children presently account for about 4 per cent of all people receiving antiretroviral drugs in those countries, while estimates based on equitable access suggest they should make up at least 13 per cent.

39. If the current trend in scaling up care and treatment continues at the same rate, the number of people receiving antiretroviral drugs in 2010 will reach approximately 4.5 million,[9] or less than half of those in urgent need of treatment. To substantially scale up treatment, far greater investment is required in the infrastructure of health systems, including human, administrative, procurement and financial resources.

40. Tuberculosis (TB) patients in high-prevalence HIV settings have high rates of HIV co-infection, and TB is one of the most common causes of illness and death in people living with HIV. In 2005, only 7 per cent of tuberculosis patients worldwide were tested for HIV; of those, 23 per cent tested positive for HIV. In Africa, where up to 80 per cent of TB patients are also HIV-positive, only 10 per cent were tested for HIV.[10] Ensuring that TB patients receive HIV testing, and thus appropriate care and treatment, should therefore be a high priority for the health sector. Similarly, people living with HIV should be screened regularly for TB, and efforts should be made to prevent the spread of TB in health-care facilities, especially in high-HIV prevalence settings. Taking these steps is particularly important in the light of the emergence of extensive drug-resistant tuberculosis (XDR-TB), a form of TB that is resistant to the most important first- and second-line anti-tuberculosis drugs, and to which people living with HIV are vulnerable because of their weakened immune systems.

41. Civil society groups and people living with HIV, in particular, must be encouraged to play their part in the scaling up of treatment. Given appropriate resources, their role in supporting communities with treatment literacy, counselling, advocacy and stigma reduction is crucial to scaling up effectively.

42. New antiretroviral drug classes are being developed. Recent developments include integrase inhibitors and chemokine receptor blockers, which provide additional types of drugs to treat people living with HIV. However, current prices preclude their use in many low- and middle-income countries, which already find it difficult to meet the higher price of second-line regimens containing branded drugs. There is clearly an urgent need for Governments to work with the pharmaceutical industry and other stakeholders to reduce the prices of second- and third-line medications for use in developing countries.

G. Trade and the Trade-Related Aspects of Intellectual Property Rights

43. In the Political Declaration on HIV/AIDS, the General Assembly underscored the importance of global trade agreements in the response to AIDS, in particular the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)[11] and the Doha Declaration on the TRIPS Agreement and Public Health.[12] The World Health Organization and the United Nations

[9] UNAIDS, resource needs technical working group, Geneva, February 2007.

[10] World Health Organization, *Global Tuberculosis Control: Surveillance, Planning, Financing. WHO report 2007* (WHO/HTM/TB/2007.376) (Geneva).

[11] See *Legal Instruments Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, done at Marrakesh on 15 April 1994* (GATT Secretariat publication, Sales No. GATT/1994-7).

[12] See World Trade Organization, document WT/MIN(01)/DEC/2. Available from http://docsonline.wto.org.

Development Programme (UNDP) continue to analyse the use of patents and the role of tariffs in access to essential medicines.

44. Over the past two years there have been signs of greater willingness of national authorities to avail themselves of the TRIPS flexibilities. In 2005, Cameroon, Eritrea and Ghana issued compulsory licences for the importation of generic HIV medicines. In November 2006 and January 2007, the Government of Thailand announced its decisions to authorize the use of two antiretroviral products that are patented in Thailand, thus allowing the Government to import and locally manufacture generic versions of these medicines.

H. Orphans and vulnerable children[13]

45. In 2005, there were an estimated 15.2 million children who had lost one or both parents to AIDS; of those children, some 80 per cent lived in sub-Saharan Africa. It is estimated that by 2010 more than 20 million children will have been orphaned by AIDS.

46. Several countries are making progress in the provision of a minimum package of services for orphans and vulnerable children, which includes access to education, health care, social welfare and protection services. In South Africa, the country with the largest number of orphans due to AIDS, more than 7.1 million children under 14 years of age and living in poverty, representing 79 per cent of those eligible, were benefiting from child support grants by April 2006. That figure represents a two-thirds increase since 2004, and a twentyfold increase since 2000.

47. Mozambique's poverty reduction strategy paper (PRSP) for 2006-2009 includes targets for school attendance, external support for caregivers and a monitoring mechanism. The PRSP prepared by the United Republic of Tanzania for 2005-2010, which was cooperatively developed with civil society, non-governmental organizations (NGOs) and local government, addresses vulnerability within an overall social protection framework. While in Botswana 95 per cent of households with at least one orphan receive some form of external support for the care of orphans and vulnerable children, in other countries the proportion is as low as 10 per cent.

48. Currently in sub-Saharan Africa, 79 per cent of children orphaned from all causes attend school. Twenty-four countries have measured the school attendance of orphans, and it has increased in 15 countries, with orphans more likely to attend school than non-orphans in several countries. Part of the progress is a result of the abolition of school fees, as in Kenya and Uganda.

I. Prevention in the spotlight

49. The universal access process is a critical opportunity to scale up HIV prevention. Data from 2005 show little progress in increasing the coverage of prevention services. The proportion of pregnant women receiving services to prevent mother-to-child transmission of HIV has increased from 9 per cent in 2005

[13] Based on UNICEF, UNAIDS and WHO, *Children and AIDS: A Stocktaking Report* (New York, UNICEF, 2007).

to only 11 per cent in 2006. Although the low rate of access to prevention services in antenatal settings is alarming, available data indicate it is possible for countries to overcome barriers to scaling up those services. At least seven low- and middle-income countries provide prevention services to at least 40 per cent of HIV-infected pregnant women, with the estimated coverage of antiretroviral prophylaxis to prevent transmission of HIV from mother to infant ranging from less than 1 per cent in some countries to 90 per cent in others.

50. According to surveys in 12 high-burden countries in sub-Saharan Africa, only 12 per cent of men and 10 per cent of women received their HIV test results. Overall, the rate of new HIV infections has greatly outpaced the expansion of HIV treatment, making it clear that the goal of halting and reversing the spread of the global HIV epidemic can be reached only if HIV prevention becomes more successful.

51. The UNAIDS publication, *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*,[14] states that the failure of HIV prevention in many countries has so far been largely attributable to three problems, as follows: (a) insufficient investment in prevention; (b) low coverage of HIV-prevention services for populations with higher rates and risks of HIV; and (c) lack of action against the social, economic and cultural drivers of HIV infection, including gender inequality, stigma and discrimination, and the failure to protect human rights. Often the gaps are due to a lack of political commitment and a preference for allocating resources to such "culturally safe" measures as basic HIV-awareness campaigns for the general population.

52. For example, there remains an unwillingness to give young people information, services and commodities in a timely manner despite sound evidence about the effectiveness of certain interventions, such as condom distribution in school. Data from Brazil indicate that although condom use has increased among adolescents in the last seven years, the proportion of adolescents engaging in sexual activity has remained stable, indicating that encouraging condom use has not encouraged increased sexual activity.

53. The coverage of basic prevention services for the populations most at risk in 2005 was less than 20 per cent. Estimates from 94 low- and middle-income countries show that the proportion of injecting drug users receiving some type of prevention services was 8 per cent in 2005, indicating virtual neglect of this most-at-risk population. Globally, only 9 per cent of men who have sex with men currently have access to HIV prevention services. Women and men engaged in sex work still receive insufficient HIV-related information and services. In most countries, prisoners receive little HIV-related health information or health care, though the provision of condoms and drug treatment to prisoners in Iran (Islamic Republic of) has shown that services for such marginalized populations are feasible and effective.

54. A number of countries are now starting to gather information on their most-at-risk populations to aid targeted prevention programmes. For example, in 2006, Algeria, Egypt, Iran (Islamic Republic of), Lebanon, Morocco, Oman and the Syrian Arab Republic assessed risk behaviours and trends among injecting drug users and

[14] Available from http://data.unaids.org/pub/Guidelines/2007/20070306_Prevention_Guidelines_Towards_Universal_Access%5d.pdf.

initiated outreach programmes. National AIDS authorities in Asian and Pacific countries explored how to mobilize political support and action to intensify HIV prevention in low-prevalence countries and to focus resources on services for vulnerable and most-at-risk groups. Eighteen countries in West and Central Africa undertook reviews of legislation on HIV and human rights, while in Latin America, a ground-breaking meeting of HIV-positive women from the region was held. Regional initiatives have taken on a greater prominence. The Abidjan-Lagos corridor initiative in West Africa — involving Benin, Côte d'Ivoire, Ghana, Nigeria and Togo — includes a strong prevention component, and it secured 46.5 million dollars from the Global Fund for 2007-2010.

55. The Southern African Development Community (SADC) has undertaken a strategic series of partnership activities to intensify HIV prevention in a region where HIV has reached adult prevalence levels greater than 15 per cent. For example, a regional think tank in Lesotho concluded that long-term, multiple concurrent sexual partnerships, lack of male circumcision and high levels of intergenerational sex, sexual coercion and gender-based violence were the principal causes of southern Africa's heterosexual epidemics. SADC has also initiated a ground-breaking effort to intensify prevention strategies, including social mobilization for social change, engaging men in changing their behaviour and engaging countries in turning the epidemic around.

56. At the global level, international consultations have been held to reinvigorate behaviour change measures to prevent sexual transmission and to define the significance of sexually transmitted infection services in controlling new and established HIV epidemics. A broad coalition of countries, donors, United Nations entities (WHO and the United Nations Children's Fund (UNICEF)), and technical support agencies has developed a global strategy for scaling up the prevention of mother-to-child transmission services. In addition, in the field of education, the High-Level Group on Education for All held its first session on AIDS in November 2006, resulting in a stronger political commitment to intensify the role of the education sector in prevention efforts.

J. New HIV-prevention interventions

57. While countries work to bring existing prevention interventions to scale, researchers have identified new public health strategies to reduce HIV transmission. In 2006, two studies in Kenya and Uganda confirmed that HIV acquisition was 60 per cent lower among adult heterosexual men who had been circumcised. The compelling scientific evidence led to a multipartner global consultation in March 2007, which recommended that adult male circumcision be promoted in areas with high HIV and low male circumcision prevalence as an additional strategy for the prevention of heterosexually acquired HIV infection in men. Joint efforts by WHO, the United Nations Population Fund (UNFPA), UNICEF and the UNAIDS Secretariat in respect of male circumcision for HIV prevention will promote responsible sexual behaviour to minimize increases in risky behaviour that result from misperception that circumcised men are no longer at risk for HIV infections. This will also promote shared decision-making in sexual matters, gender equality, and improved sexual and reproductive health for both women and men.

58. The Global HIV Vaccine Enterprise has rallied scientists, activists, funders and other stakeholders worldwide around a strategic scientific plan to accelerate progress in developing an effective HIV vaccine. More than 30 vaccine candidates for the prevention of HIV are in the early stages of human clinical trials in about two dozen countries, and two vaccine candidates are in large-scale efficacy trials.

59. A safe and effective microbicide has not yet been found, but nearly a dozen microbicides have entered human testing. Two of the microbicide candidates appeared to increase the risk of HIV acquisition in women. However, three first- and second-generation microbicide products remain in large-scale efficacy trials, all involving African study sites. Trials are under way or being planned to test the use of certain antiretroviral drugs to prevent sexual or blood-borne transmission of HIV through pre-exposure prophylaxis. Two clinical trials are currently assessing the efficacy of preventing HIV through the suppression of herpes simplex virus type 2, which is known to increase the risk of HIV transmission and acquisition.

K. Universal access and United Nations reform

60. The joint efforts of specialized agencies and organizations of the United Nations system to support the global AIDS response has steadily improved since UNAIDS was founded in 1996. To better act as "One United Nations" at the country level, the UNAIDS Secretariat and its 10 Co-sponsoring agencies[15] examined the comparative advantages among United Nations entities for the delivery of technical support to national partners. This division of labour provides clarity about which organization is responsible and accountable for taking the lead in 17 key programmatic areas.

61. Following a December 2005 directive by the Secretary-General, United Nations resident coordinators have established joint United Nations teams on AIDS in at least 65 countries. The teams focus on technical support and guidance, but also act as advocates for resource mobilization, help countries coordinate key areas of the response and, in the case of some United Nations entities (e.g. the World Food Programme (WFP), the Office of the United Nations High Commissioner for Refugees (UNHCR) and UNICEF), provide direct prevention, treatment and care services.

62. In 2006, UNAIDS technical support facilities provided technical assistance to countries at the request of joint United Nations teams across five regions in a number of priority areas, including strategic and operational planning, monitoring and evaluation, and organizational development.

63. The World Bank, UNDP and the UNAIDS Secretariat have built the capacity of countries to develop focused, prioritized, evidence-based and costed strategies and action plans on AIDS and to integrate AIDS priorities into poverty reduction strategy papers and national development plans.

64. The World Health Organization has been involved with the development and dissemination of relevant strategic technical information on treatment regimens, the use of patents for medical technologies, injection safety, HIV case reporting,

[15] UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank.

preventing mother-to-child transmission and estimating the size of human resource needs in the health sector, including the role of task shifting among health providers.

65. A number of the specialized agencies of the United Nations have focused on key neglected areas. The United Nations Population Fund (UNFPA) provided support on condom programming and procurement management in 90 countries. The United Nations Office on Drugs and Crime (UNODC) worked with 25 countries on policy and legal reviews and on implementing evidence-informed HIV prevention and care programmes for injecting drug users and in prison settings. The United Nations Educational, Scientific and Cultural Organization (UNESCO) supported efforts by ministries of education in over 70 countries to strengthen HIV prevention programmes, and, by the end of 2006, 29 countries had developed comprehensive HIV education strategies within the context of the Global Initiative on Education and HIV and AIDS (EDUCAIDS) framework for action. The International Labour Organization (ILO) promoted the world-of-work response to AIDS as a development concern and helped formal occupational health services extend HIV prevention, care and treatment to the families of their workers and local communities.

66. Finally, the United Nations System HIV-Positive Staff Group (UN+) representing the estimated 3,500 United Nations employees living with HIV, was established in 2006 to ensure that staff have access to appropriate services and are able to work in conditions free of stigma and discrimination. The Group now has more than 100 members in 35 countries, representing 22 agencies, programmes and associated organizations.

L. Moving forward: sustaining the response

67. As countries move towards universal access, the foundations must be established for a response that can be sustained over the long run. As the number of health facilities offering HIV services increases, capacity must also be expanded to ensure the staff, equipment, laboratory support and drug procurement necessary to provide services and the regular monitoring and evaluation of those services.

68. When strategically used, funds for AIDS can improve health infrastructure, leading to increased immunizations for children, safer hospital environments, better equipped laboratories and better access to basic primary prevention and treatment services for other health problems. For example, a study of a primary health-care programme in Haiti found that robust HIV prevention efforts and community-based therapy for people with advanced AIDS had a favourable impact on a number of primary health-care goals, including vaccination, family planning, tuberculosis case finding and cure, and the promotion of health.[16]

69. The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, initially conceived as an AIDS fund, has significantly improved the level of resources for two other global health problems, tuberculosis and malaria. The improvement of procurement and logistics systems for condoms, HIV drugs and HIV diagnostics can increase the supply of other critical commodities. Finally, AIDS efforts can help the education sector with increased resources for school supplies and teacher training.

[16] David A. Walton, and others, "Integrated HIV prevention and care strengthens primary health care: lessons from rural Haiti", *Journal of Public Health Policy*, vol. 25, No. 2.

70. Innovative, long-term strategies are needed to ensure the availability of qualified health-care staff. Training additional health workers is only part of the solution. Governments must also encourage staff working in public health facilities of low- and middle-income countries to stay in their jobs rather than move from rural to urban areas or move abroad or to the more lucrative private sector. Such retention schemes are likely to include such incentives as improvements in salary and working conditions, and must be included within costed national strategies.

71. Owing to the size and urgency of the global AIDS epidemic, the response to date has had to be exceptional, with its specific funding, governance and implementation mechanisms. Mainstreaming of the AIDS response should also be promoted by encouraging all relevant government agencies to collaborate in the planning, integration and delivery of HIV-related services. Where both public and private sectors play an important role in the delivery of HIV services, countries will need to work to ensure that the private sector supports the goal of equitable access. However, given the severity of the existing challenges, it would be a fatal mistake if the exceptional response to AIDS were now abandoned.

III. Recommendations

72. One year after the adoption of the Political Declaration on HIV/AIDS, important groundwork has been laid for a longer-term effort to move towards universal access. However, many countries continue to struggle in order to significantly increase the pace of expansion and move towards the goal of universal access by 2010. Efforts to set national targets for universal access have highlighted fundamental challenges. Those challenges can best be addressed through a concerted, multisectoral effort among major stakeholders responding to the following five recommendations:

- **Know your epidemic and intensify HIV prevention**. To know their epidemic, countries must establish an integrated epidemiologic surveillance, monitoring and evaluation system to collect strategic information and to develop and refine the national AIDS plan. "Knowing your epidemic" also means understanding the effectiveness of the response — both for prevention and for treatment, including the actual recipients of the services. Limited resources can then be targeted where they are most needed: high-transmission areas, populations most at risk of HIV infection, the underlying conditions that facilitate transmission of HIV and the critical obstacles to scaling up programmes. In many countries, insufficient political will to focus on the drivers of the epidemic — including gender inequality, stigma and discrimination and the failure to protect other human rights — is limiting progress on HIV prevention. Efforts to address the needs of women and girls, children and orphans, young people, migrants and highly stigmatized populations such as sex workers, men who have sex with men, injecting drug users and prisoners, must become programmatic priorities in national AIDS plans that are costed, budgeted and implemented. Similarly, prevention and treatment efforts need to be scaled up in emergency and displacement settings for affected populations as well as for the surrounding host populations. National civil society organizations and networks of people living with HIV are critical players in this effort, as they can represent the interests of affected groups and help to deliver services to them.

- **Chart a course towards universal access.** Universal access targets must be both ambitious and grounded in reality. Achieving this balance requires careful estimation of the resources needed to overcome obstacles to scaling up, for both health and non-health sectors. It is equally important to understand the current levels and quality of service coverage and the capacity to scale up those services. Such information is critical for the development or revision of national AIDS plans that identify financial gaps for each programme or service and beneficiary population, and can serve as a powerful tool to mobilize additional resources and reach the levels of service coverage envisioned by universal access. Part of the process must include prioritizing key elements of the AIDS plans based on knowledge about what is actually effective and acknowledging the possibility of not obtaining all requested resources. Therefore, well-elaborated, costed national AIDS action frameworks and priority action plans are a critical prerequisite of successful implementation.

- **Fund an ambitious, credible national AIDS plan and align it with national systems.** The international community acknowledged in the Political Declaration that there is a substantial financing gap for the AIDS response, and it pledged to ensure that credible and sustainable national plans were funded and implemented. Without additional funding commitments — both from donors and from national budgets — low-income countries and some middle-income countries cannot set ambitious targets to move towards universal access. The international community must also follow up on commitments to align external support around national plans and systems, as outlined in the "Three Ones" principles. The country harmonization and alignment tool provides low- and middle-income countries with an action-oriented approach to reviewing and improving participation, coordination and alignment of donor activities within the national AIDS response, and low- and middle-income countries should be encouraged to use the tool for those purposes.

- **Build capacity for a stronger, more sustainable response.** Significant investments in infrastructure and in human resources are of the utmost importance if low- and middle-income countries are to absorb resources and build a robust and sustainable response to HIV. The long-standing shortage of human resources for health in low-income countries has only become more acute as a result of HIV. There is a need to train additional health personnel, retain physicians and nurses who want to leave the public sector to improve their own working conditions and replace those who have been lost to the HIV epidemic. Sustainability will also require HIV programmes to become more integrated with the local health system and other relevant services in order to help build high-quality social sector services. However, universal access cannot be achieved by the public sector alone. All relevant government agencies must engage civil society so it can make its valuable contribution to the delivery of HIV-related services and to the monitoring of national performance. Government partnerships with the private sector and non-governmental organizations can provide publicly funded services to an increasing number of people. Only through this broader, integrated strategy, will it be possible to achieve Goal 6 of the Millennium Development Goals, to combat HIV/AIDS, Malaria and other diseases, as well as the other Millennium Development Goals that are affected by the epidemic.

- **Report progress on international commitments**. Countries should prepare for the 2008 comprehensive AIDS review by strengthening their surveillance and monitoring and evaluation systems. As provided in the Political Declaration on HIV/AIDS, the review of progress on AIDS in 2008 will include a comprehensive update by countries on performance indicators for the Declaration of Commitment on HIV/AIDS. UNAIDS has sent all Member States guidelines on the revised set of indicators, and the reporting deadline is 31 January 2008. As in the last round of reporting, national civil society groups should be encouraged and supported to play a monitoring function in the reporting progress, working with the formal process and also through the submission of shadow reports. A comprehensive report on progress will be prepared and presented at the 2008 meeting of the General Assembly.